DEPARTMENT OF MENTAL HEALTH, RETARDATION AND HOSPITALS
ELEANOR SLATER HOSPITAL
P.O. Box 8269
Cranston, RI 02920
401.462.3433 – OFFICE
401.462.6958 – FAX

APPLICATION FOR ADMISSION

( ) CRANSTON UNIT ( ) ZAMBARANO UNIT

***OPTIMAL LOCATION WILL BE DETERMINED BY PATIENT'S NEEDS. PREFERENCES MAY BE HONORED, BUT CANNOT BE GUARANTEED*

Name of Applicant: _____

Residence: _____

Date of Birth: _____ Race: _____ Religion: _____ Marital Status: _____ Sex: _____ Legal Status: _____

Social Security #: _____ Name of Insured if other than Applicant: _____

Medicare #: _____ Federal ☐ Medicare Replacement Plan (HMO) ☐ Agency: _____

If Supplemental Plan to Medicare Please Specify: _____ ID #: _____

Medicare Part D Plan: _____ ID#: _____ BIN: _____ PCN: _____

Blue Cross #: _____ Veteran's #: _____ Other : _____
ID #: _____

Medical Assistance #: _____
(R.I. Only) If pending, list name of office/worker to contact

Include Photocopies of All Medical Coverage Cards

Referral From (Home, Nursing Home, Community Agency, etc.)

Name: _____ Address: _____

Contact Person: _____ Telephone: _____

Family, Significant Other Supports

NAME	ADDRESS	TELEPHONE (HOME/WORK)	RELATIONSHIP

How often have family, significant other supports visited the applicant in the last two months?
( ) Daily ( ) 2-3 times per month
( ) More than a week ( ) Once a month
( ) Once a week ( ) Less than once a month
( ) N/A

How often have they provided care/assistance to the applicant in the last two months?
( ) Daily ( ) 2-3times per month
( ) More than a week ( ) Once a month
( ) Once a week ( ) Less than once a month
( ) N/A

Advance Directive:

Living Will	( ) Yes	( ) No	( ) Unknown
Durable Power of Attorney for Healthcare:	( ) Yes	( ) No	( ) Unknown
Is Guardianship Pending?	( ) Yes	( ) No	( ) Unknown

_____ _____
Applicant's Signature (If Unable to sign, Guardian or Relative) Date

Eleanor Slater Hospital is a facility that provides Long-Term Acute Care; Patients accepted for admission MUST QUALIFY FOR HOSPITAL LEVEL OF CARE. If / when patients no longer qualify for hospital level services as determined by the treatment team, discharge to a less restrictive environment becomes mandatory under Federal guidelines.

Reason for Referral to Eleanor Slater Hospital (Circle All That Apply and Elaborate Below):

Medical Behavioral Psychosocial Psychiatric

Has the Patient Sought Admission Elsewhere? (Circle One): YES NO

If YES, Where? What were the decisions?

If NO, Please Explain.

Does the Patient Have a Discharge Goal After Eleanor Slater Hospital? (Circle One) YES NO

If YES, What is the Goal: (Please check options)

( ) Home(Alone) ( ) Assisted Living

( ) Home (w/Family) ( ) Group Home

( ) Nursing Home ( ) Other (Please Specify):

Who Will be Responsible for This Patient's Care: (Name / Address**)

*****This individual's active, early involvement in the admission process is strongly encouraged to facilitate the eventual discharge goal. A conference may be requested prior to admission.***

If No Discharge Goal Exists, Please Explain Long-term Goals for This Patient (1-5 Yrs From Now):

ALL INFORMATION MUST BE COMPLETE AND ACCURATE. PLEASE INCLUDE COPIES OF SUPPORTIVE DOCUMENTATION (Physician's progress notes, Physician's orders, Nurses' notes, consultations, Therapist's notes, etc.)

To be completed by physician, nurse, or case manager – Please check appropriate boxes

ACCESS/OSTOMY
- ☐ NG/G/J Tube
- ☐ IV/IV Access
- ☐ Trach
- ☐ Ostomy

MEMORY
- ☐ Normal
- ☐ Mildly Impaired
- ☐ Moderately Impaired
- ☐ Severely Impaired

COMMUNICATION
- ☐ Normal
- ☐ Language Barrier
- ☐ Comprehends
- ☐ Can Relate Needs
- ☐ Aphasic/Non-communicative

BEHAVIOR
- ☐ No Significant Disorder
- ☐ Appears Depressed
- ☐ Wanders
- ☐ Noisy
- ☐ Withdrawn
- ☐ Physically Assaultive
- ☐ Verbally Abusive
- ☐ Intrusive
- ☐ Combative During Care
- ☐ Sexually Inappropriate

SENSORY
- ☐ Hearing Impairment
- ☐ Vision Impairment

CONDITIONS
- ☐ Pressure Sores/Wound Care
- ☐ Contractures

CONTINENCE
- ☐ Continent
- ☐ Incontinent Urine/Feces

Please attach a description of any particular management issues (Patient and/or Family) of which the Eleanor Slater Hospital Admission Team should be aware of.

ADL	Independent	Needs Assistance	Unable
Transfers	☐	☐	☐
Ambulation	☐	☐	☐
Ambulating w/ device	☐	☐	☐
Wheelchair	☐	☐	☐
Bathe Self	☐	☐	☐
Dress Self	☐	☐	☐
Feed Self	☐	☐	☐
Toilet/Commode	☐	☐	☐
Bedpan/Urinal	☐	☐	☐

SPECIAL EQUIPMENT

Special Equipment Needed: _____

Air Fluidized Beds: _____

Other (describe): _____

ALLERGIES:

_____

_____

DIET:

_____

_____

FOOD & FLUID INTAKE:
- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

HEIGHT: _____

WEIGHT: _____

DIAGNOSES/PROBLEMS

I. _____ IV. _____

II. _____ V. _____

III. _____

MEDICATIONS (Dose & Route) TPN & IV

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

PROGNOSIS ( ) GOOD ( ) FAIR ( ) POOR ( ) GUARDED

_____

_____

TREATMENTS: (Check Box)

☐ PT (Describe) _____ Respiratory: _____

☐ OT (Describe) _____ Skin/Wound Care: _____

☐ Speech (Describe) _____ Other: _____

INFECTION CONTROL

☐ MRSA

☐ VRE

☐ Special Isolation (Describe) _____

Name of Physician: _____ **Telephone:** _____ **Date of Last Examination:** _____

Signature of Physician: _____ **Date:** _____